

**INSTRUCTIONS FOR COMPLETING  
THE ADULT CARE HOME SCU-A PRIOR  
APPROVAL FORM**

1. This form is only to be used by Adult Care Homes with Special Care Unit Designations which is available on DMA's website at <http://www.ncdhhs.gov/dma/forms.html#prov>. When printing this form ---print it "Landscape".
2. Print clearly.
3. All copies of items submitted must be legible.
4. The complete facility information is only due once per year- as per schedule or upon facility status change or as otherwise needed.
- 5. THIS IS A HIPAA REQUIREMENT: The completed form and information must be sent in a sealed envelope with "confidential" written in red and then placed in another envelope and addressed as in #6 below. DMA will not accept faxed records.**
6. Completed form must be sent via US Mail to the following address:  
NC DHHS – DMA  
ACH Unit  
Facility and Community Care  
1985 Umstead Drive  
2501 Mail Service Center, Raleigh, NC 27699-2501
7. For questions contact:  
Nancy Roberts @ 919-855-4116 or [Nancy.Roberts@ncmail.net](mailto:Nancy.Roberts@ncmail.net) or  
Julie Budzinski @ 919-855-4368 or [Julie.Budzinski@ncmail.net](mailto:Julie.Budzinski@ncmail.net)

**Must be mailed to:**  
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ACH—Facility and Community  
Care  
1985 Umstead Drive  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**North Carolina  
Division of Medical Assistance**

**SPECIAL CARE UNIT –A  
PRIOR APPROVAL**



ACH Name \_\_\_\_\_ Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ County \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_ DFS License# \_\_\_\_\_ Total # ACH Beds \_\_\_\_\_  
ACH Provider # \_\_\_\_\_ # SCU-A Beds \_\_\_\_\_ Freestanding SCU-A ☐ yes ☐ no Other Specialty Designation \_\_\_\_\_

Resident Name \_\_\_\_\_ MID# \_\_\_\_\_ DOB \_\_\_\_\_  
Date of Admission to SCU-A: \_\_\_\_\_ New Admission to ACH ☐ yes ☐ no Readmission to ACH ☐ yes ☐ no  
New Admission to SCU-A ☐ yes ☐ no Readmission with change of condition ☐ yes ☐ no  
Resident is currently receiving Enhanced ACH/PCS ☐ yes ☐ no Case Manager \_\_\_\_\_ Phone \_\_\_\_\_

**THE FOLLOWING INFORMATION MUST BE ATTACHED TO THIS FORM FOR PRIOR APPROVAL TO BE CONSIDERED : (SUBMIT ONLY ONCE PER YEAR—AS PER SCHEDULE OR UPON RESIDENT/FACILITY STATUS CHANGE OR AS OTHERWISE NEEDED)**

**A. REQUIRED RESIDENT INFORMATION:**

\_\_\_\_\_ FL2 Completed within the last six months as of 10/1/06 , signed by a physician and showing a diagnosis of  
Alzheimer's and related disorders.

\_\_\_\_\_ Pre-Admission Screening showing appropriateness for the recipient's placement in the SCU-A.

\_\_\_\_\_ Copy of Care/Service Plan for SCU-A for residents admitted 30 days or more prior to Date of Service 10/01/06

**B. REQUIRED FACILITY INFORMATION :**

\_\_\_\_\_ SCU-A DISCLOSURE STATEMENT \_\_\_\_\_ CURRENT ACH LICENSE SHOWING SCU-A DESIGNATION

**I CERTIFY THE ABOVE AND ATTACHED INFORMATION IS CORRECT AND ACCURATELY REPRESENTS THE IDENTIFIED RESIDENT AND THE SCU-A PROGRAM.**

\_\_\_\_\_ SIGNATURE ADMINISTRATOR \_\_\_\_\_ DATE  
\_\_\_\_\_ PRINT NAME CLEARLY

**For office use only:**

Date: Received \_\_\_\_\_ Date processed \_\_\_\_\_ Date Approved \_\_\_\_\_ Code \_\_\_\_\_ Date Denied \_\_\_\_\_ Code \_\_\_\_\_  
DDL \_\_\_\_\_ DK \_\_\_\_\_